Choice CORE Plan

Core Plan

Choice plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Core Plan

Types of Coverage	Network Benefits
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description available on the workforce services portal.** If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services. Failure to obtain prior notification may result in a reduced benefit.	**Annual Deductible:** $1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $4,000 per Covered Person per calendar year, not to exceed $8,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible.. **Maximum Plan Benefit:** No Maximum Plan Benefit.
1. Ambulance Services - Emergency only	Ground Transportation: 20% of Eligible Expenses Air Transportation: 20% of Eligible Expenses
2. Dental Services - Accident only	*20% of Eligible Expenses *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Benefits for Durable Medical Equipment are limited to $2,500 per calendar year. **Hearing Aids are limited to one every 3 years and a separate $2,500 per calendar year maximum.**	20% of Eligible Expenses
4. Emergency Health Services	20% of Eligible Expenses
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	20% of Eligible Expenses
6. Home Health Care Benefits are limited to 60 visits for skilled care services per calendar year.	20% of Eligible Expenses
7. Hospice Care	20% of Eligible Expenses
8. Hospital - Inpatient Stay	20% of Eligible Expenses
9. Injections Received in a Physician's Office	20% of Eligible Expenses
10. Maternity Services	Same as 8, 11, 12 and 13

Types of Coverage	Network Benefits
11. Outpatient Surgery, Diagnostic and Therapeutic Services	
Outpatient Surgery	20% of Eligible Expenses
Outpatient Diagnostic Services	Preventive: For lab and radiology/Xray: 100% of Eligible Expenses For mammography testing: 100% of Eligible Expenses Diagnositc: For lab and radiology/Xray: 20% of Eligible Expenses For mammography testing: 20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses
Outpatient Therapeutic Treatments	20% of Eligible Expenses
12. Physician's Office Services	Preventive medical care: 100% of Eligible Expenses Sickness & Injury: 20% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses
14. Prosthetic Devices Benefits for prosthetic devices are limited to $2,500 per calendar year.	20% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Benefits are limited as follows: 60 visits of physical therapy; 60 visits of occupational therapy; 60 visits of speech therapy; 60 visits of pulmonary rehabilitation; and 60 visits of cardiac rehabilitation per calendar year.	20% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Benefits are limited to 60 days per calendar year.	*20% of Eligible Expenses
18. Transplantation Services	*20% of Eligible Expenses
19. Urgent Care Center Services	20% of Eligible Expenses

Additional Benefits

Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee	20% of Eligible Expenses
Mental Health and Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee.	20% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to 20 visits per calendar year.	20% of Eligible Expenses
Reproduction Benefits include Voluntary sterilization, Health services and associated expenses for Therapeutic abortion, Contraceptive supplies and services, Fetal reduction surgery..	Same as 8, 11, 12 and 13
Tempormandibular Joint Syndrome (TMJ) Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.	20% of Eligible Expenses

Core Choice Plan
Exclusions

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Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments
Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience
Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental
Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs
Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services
Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care
Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances
Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition
Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. Exception Enteral formulas necessary for the treatment of Phenylketonuria (PKU) or other heritable diseases

J. Physical Appearance
Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, unless the result of chemotherapy..

K. Providers
Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction
Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization. Elective abortions.

M. Services Provided under Another Plan
Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants
Health services for organ or tissue transplants, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel
Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision
Purchase cost of eye glasses or contact lenses. Fitting charge for eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity), **except for diagnosis of morbid obesity.**

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly

Choice Core Plan *Pharmacy*

The pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications

While most pharmacies participate in the network, you should check first. Call your pharmacist or visit the online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

Coinsurance per Prescription Order or Refill

Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the Home Delivery Pharmacy's Prescription Drug Cost.

Also note that some Prescription Drug Products require that you notify the Claims Administrator's designee in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

	Retail Network Pharmacy For up to a 31 day supply	**Home Delivery Network Pharmacy** For up to a 90 day supply
Tier 1 (Typically Generic)	10%	10%
Tier 2 (Preferred Brand)	20%	20%
Tier 3 (Non-Preferred Brand)	35%	35%
Tier 4* (Specialty)	50%	50%

*Specialty medications are typically more than $250 per prescription, in an injectable or oral form, treat rare or complex diseases and typically require additional clinical support for better health outcomes.

Starting on January 1, 2010, you will need to use Prescription Solutions, UnitedHealthcare's new in-network specialty pharmacy provider, to receive in-network coverage for your specialty medication. You can continue to fill your *non-specialty* prescriptions at your regular retail or mail order pharmacy.

- Call Prescription Solutions as soon as possible at 1-888-739-5820 and one of their staff will obtain your information, ID number, and doctor's information and then contact your doctor to get a new prescription for your specialty medication.
- Prescription Solutions can help answer any questions you have and will begin the process of working with you and your health care provider to fill your specialty medication.
- Prescription Solutions will also work with you to schedule your delivery or even arrange for emergency delivery, if necessary.

For more information about our program or to get started ordering your specialty medication(s), please contact Prescription Solutions at 1-888-739-5820. Representatives are available 5:00 a.m. to 7:00 p.m. Pacific Time, Monday through Friday. On-call pharmacists are available 24 hours a day, seven days a week for emergency situations.

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Other Important Cost Sharing Information

Annual Drug Deductible	No Annual Drug Deductible
Out-of-Pocket Drug Maximum	$1,000 Out-of-Pocket Drug Maximum

Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed. Prescription Drug Products when prescribed to treat infertility.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by the Prescription Drug List Management Committee. Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).